Authorization for the Release or Exchange of Information
with
Kathryn Gates, LMFT
512.814.6580

Patient Name:_____ DOB:_____

Release and/or Exchange is permitted with:

_____

Phone: _____ Email:_____

Fax: _____ Address: _____

_____

The following, as checked, may be exchanged or released:

__ Confirmation of therapeutic relationship __ Attendance records

__ Summary of work/notes __ Any/All, as deemed relevant

For the purpose of:

_____

Additional Notes:

_____

_____

_____

This release applies for **the duration of treatment**
or
for **_____month(s) from date signed**.
(please circle)

_____

Signature of Patient and/or Legal Guardian Date